FR-10

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

08464

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Rural Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or Institution:

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Brunswick Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sterling Leon O. Ambrose

3. (b) Social Security Number

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosie G. Ambrose

6(c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) Aug 29 - 1911

8. AGE: Years 28 | Months 11 | Days 27 | If less than one day ___ hrs. ___ min.

9. Birthplace Rippon - W Va
(Town, county, and state)

10. Usual occupation Brakeman

11. Industry or business B and O Railroad

FATHER
12. Name George E. Ambrose
13. Birthplace W. Va

MOTHER
14. Maiden name Lena P. Bohrer
15. Birthplace W Va

16. Informant C. L. Feete
Address Brunswick Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Aug. 28 1940
(month) (day) (year)

Cemetery or crematory Brunswick

Location Brunswick Md.

18. Funeral director C. H. Feete & Bro.
Address Brunswick, Md.

19. Aug. 26 1940 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1940, at 8.50 p M about

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —, and that I last saw ~~n~~ alive on — 19 —.

Immediate cause of death Fracture skull
Broken neck -
Fracture left hip -
~~Due to~~ 2nd and 3rd degree burns -

Due to Railroad accident -
Engine turned over -

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

DURATION
7
7
7
7

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Aug 25/40
Where did injury occur? Sykesville (City or town) Carroll (County) Md. (State)
Injured at home, farm, industry, public place (where?) Railroad
Means of injury Railroad Accident Injured at work? Ye

23. SIGNATURE Jos. T. Marsh Deputy Medical Examiner
M. D. or other
Address New Windsor Md Date signed Aug 26-1940

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (95-2)

Reg. Dist. No. 78

08465

CERTIFICATE OF DEATH

1. PLACE OF DEATH

(a) County Carroll

(b) City or town near Taylorsville (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 20 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Carroll

(c) City or town Rural (If outside city or town limits, write RURAL and give town)

(d) Street No. Taylorsville (If rural give location)

(e) If foreign born, how long in U. S. A.? American years

3 (a) FULL NAME Arthur Clayton Baile

3 (b) If veteran, name war none

3 (c) Social Security No. None

4. Sex Male

5. Color or race white

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Fannie Mae Wetzel

6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Aug 5 1867

8. AGE: Years 73 Months 0 Days 5 If less than one day ___ hr. ___ min.

9. Birthplace Carroll Co Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Fletcher Baile

13. Birthplace not known

MOTHER 14. Maiden Name Sally Pennington

15. Birthplace not known

16 (a) Informant Mrs Fannie M Baile

(b) Address Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15 (month) (day) (year)

(c) Cemetery or crematory Ebinezer Cem

Location near Winfield

18 (a) Funeral director D D Hartley Sons

(b) Address New Windsor Md

19 (a) Aug 13, 1940 (Date rec'd by registrar) E. M. Farver Local Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 12 1940 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940, to Aug 12 1940, and that I last saw him alive on Aug 12 1940

Immediate cause of death Prostatic Hypertrophy — Duration 2 yrs.

Due to Generalized Arteriosclerosis — 10 yrs.

Due to Cardiac Dilatation — 1 da.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jas. T. Thomas M D M. D. or other

Address New Windsor Md Date signed 8/3/40

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08466

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (139-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo - 6 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 6 mo - 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltro

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 106 W Univ. Parkway Baltro (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Marie A. Baldwin

3.(b) Social Security Number: —

4. Sex: female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 28th - 1882

8. AGE: Years: 58 Months: 2 Days: 8 If less than one day: ..... hrs. ..... min.

9. Birthplace: Boston, Mass. (Town, county, and state)

10. Usual occupation: At home

11. Industry or business:

FATHER
12. Name: Loamni Baldwin
13. Birthplace: Boston Mass

MOTHER
14. Maiden name: Adele French
15. Birthplace: Binghamton N.Y.

16. Informant: Mrs Alice Stewart

Address: 106 W Univ. Parkway Baltro

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 10, 1940 (month) (day) (year)

Cemetery or crematory: Greenmount Cem.

Location: Balto Md.

18. Funeral director: John O. Mitchell

Address: 1900 Eutaw Place

19. Aug. 9 1940 (Date rec'd by registrar) C. Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 9th 1940, at 12-20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2d 1940, to Aug 9 1940 and that I last saw her alive on Aug 8th 1940

Immediate cause of death: Gas gangrene of vulva & inguinal region

Due to: Bacillus to be determined later

Due to: probable Clostridium Welchii

Other conditions: (Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. N. Martin M.D. M. D. or other

Address: Sykesville Md. Date signed: Aug 9-40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (83E)

08467

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster (Rural)
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Charles Street
Stay in hospital or inst. (yrs., or mos., or days) X
Stay in this community (yrs., or mos., or days) about 70 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Charles Street
(If rural give LOCATION)
2(o) IF VETERAN, NAME WAR X

3. (a) FULL NAME Mary A. Gibson Barnhart

3. (b) Social Security Number X None

4. Sex f.
5. Color or race Colored
6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife Lewis Barnhart deceased
6(c) If alive, give age X years
7. Birth date of deceased (mo., day, yr.) Mar. 9, 1864
8. AGE: Years 76 Months 5 Days 5 If less than one day ___ hrs. ___ min.
9. Birthplace Sams' Creek Carroll Co. MD.
(Town, county, and state)
10. Usual occupation House wife
11. Industry or business X
FATHER 12. Name Orrie Owens
13. Birthplace Maryland
MOTHER 14. Maiden name Narcissa Barnes
15. Birthplace Maryland
16. Informant Luther Gibson
Address Westminster, Md.
17. Burial Date thereof 8 15 40
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Ellsworth Cem.
Location Near Westminster, Md.
18. Funeral director J. E. Myers Jr.
Address Westminster Md.
19. 8/13 1940 [signature]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12th 1940, at 10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1st 1940, to Aug. 12 1940, and that I last saw her alive on Aug. 12th 1940.
Immediate cause of death Cerebral Thrombosis
Due to Arteriosclerosis
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION: 2 weeks ago; about 5 yrs.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Billingslea M. D. or other
Address Westminster, Md. Date signed 8/13/40.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 4 1940
BUREAU V. S.

08468

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92C)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll.

County

City or town Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 10 mos., 13 days.

Hospital, institution, or street address where death occurred: Springfield State Hospital.

How long in hospital or institution? 4 yrs., 10 mos., 13 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 622 Edgewood.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Morris Baseman.

3.(b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Widowed (?).

6.(b) Name of husband or wife Florence Sickel.

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 16, 1892.

8. AGE:

Years	Months	Days	If less than one day
48	4.	21.	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Plumber.

11. Industry or business

FATHER
12. Name John F. Baseman,
13. Birthplace Maryland.

MOTHER
14. Maiden name Mary Hedrick.
15. Birthplace Maryland.

16. Informant Springfield Hospital Record.
Address Sykesville, Md.

17. Bureal
(Burial, cremation, or removal? Which?)
Date thereof Aug. 10, 1940
(month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto. Md.

18. Funeral director Wm Cook.

Address 1217 St. Paul St. Balto.

19. Aug. 7 1940 C. Harry Weir
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1940, at 3.15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1936, to Aug. 7, 1940, and that I last saw him alive on Aug. 7, 1940.

Immediate cause of death Coronary Occlusion — DURATION One day.

Due to Chronic Rheumatic Endocarditis prior to 9-24-35.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry F. Baer, M.D.
M. D. or other

Address Sykesville, Md. Date signed 8-7-40.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 10 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(77)

08469

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Manchester

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 60 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Carroll

City or town Manchester Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Augusta W Bergman

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 19 - 1853

8. AGE:

Years	Months	Days	If less than one day
87	4	11	hrs. min.

9. Birthplace Germany

(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name John G Bergman

13. Birthplace Germany

MOTHER 14. Maiden name Fredricka D Lamb

15. Birthplace Germany

16. Informant Mrs W L F Bergman

Address Manchester Md

17. Burial Date thereof Aug 31/40

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Manchester

Location Manchester Md

18. Funeral director Edw C Tipton

Address Hampstead Md

19. Aug 31 1940 Mrs. W. L. F. Stenner

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1940, at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1938, to Aug 30 1940, and that I last saw her alive on Aug 29 1940.

Immediate cause of death	Arteriosclerosis	DURATION 10 yrs
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William R S Dennel M. D. or other

Address Manchester Md Date signed 8/31/40

CEIVED
SEP 5 1940
U. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08470

CERTIFICATE OF DEATH

(93d)

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster Rural Near

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 69 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Rural near Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lillian Beggs

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	widow

6 (b) Name of husband or wife Theodore H. Beggs

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August - 1855

8. AGE:

Years	Months	Days	If less than one day
85			hrs. min.

9. Birthplace Belfast, Ireland (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER

12. Name Not known

13. Birthplace — —

MOTHER

14. Maiden name Not known

15. Birthplace — —

16. Informant James Beggs

Address Westminster, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 18-1940 (month) (day) (year)

Cemetery or crematory Beggs Cemetery

Location Nr. Westminster, Maryland

18. Funeral director H Bankard & son

Address Westminster Maryland.

19. 8/17 1940 [signature] (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16th 1940, at 12 30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1st 1938, to Aug. 16th 1940, and that I last saw her alive on Aug. 15 1940.

Immediate cause of death	DURATION
Chronic myocarditis	10 yr.
Due to Senility	15 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. L. Billingsley M. D. or other

Address Westminster, Md. Date signed 8/17/40

RECEIVED
SEP 4 1940
[illegible] V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

08471

1. PLACE OF DEATH

County Carroll Registration Dist. No. 76

Village or City rural near Finksburg No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 71 yrs. 4 mos. 6 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mollie Brauning If U. S. Veteran, specify WAR

(a) Residence: No. rural near Finksburg St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	white	widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L. Brauning

6. DATE OF BIRTH (month, day, and year) April 20, 1869

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME Lewis L. Shipley

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Christine Undercork

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Horace S. Brauning (Address) Finksburg, Md.

18. BURIAL, CREMATION, OR REMOVAL Place Gamber, Md. Date Aug. 28, 1940

19. UNDERTAKER J. Francis Reese (Address) Westminster, Md.

20. FILED 8/27, 1940 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Aug (Month) 28 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 1st, 1940 Aug 28, 1940 I last saw her alive on Aug 28, 1940; death is said to have occurred on the date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Carcinoma of Liver	2 yr

Other Contributory Causes of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) [illegible] M. D.

(Address) Westminster Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE FLEASLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

08472

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-6

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 25 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 3 months, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 N. Bruce St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOSEPH BROWN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 7, 1902

8. AGE:

Years	Months	Days	If less than one day
38	1	12	..... hrs. ..... min.

9. Birthplace: Morganza, Maryland.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER
12. Name: David Brown
13. Birthplace: unknown

MOTHER
14. Maiden name: Lena Jennifer
15. Birthplace: Hillville, Maryland

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/22/1940 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Baltimore City

18. Funeral director: Geo G. Kelson

Address: 1303 Pressman St.

19. August 19 40 (Date rec'd by registrar) Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19, 1940 19..... at 11:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25, 1940 19..... to August 19 19 40 and that I last saw him alive on August 19 19 40

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op. --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: -

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. Superintendent M. D. or other

Address: Henryton, Maryland Date signed: 8/19/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

08473

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Rural m. Bird Hill
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 51 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.D. Westminster, Md
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Margaret E. Caples

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: George W. Caples

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 13, 1864

8. AGE: Years: 45 Months: 11 Days: 18 If less than one day ____ hrs. ____ min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Housework.

11. Industry or business

FATHER
12. Name: Andrew J. Easton
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Margaret Shipley
15. Birthplace: Maryland.

16. Informant: Mr. William Caples
Address: R.D. Linksburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 3, 1940 (month) (day) (year)

Cemetery or crematory: Zion Meth.

Location: near Bird Hill, Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 9/2 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 31, 1940, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~Sept.~~ August 12th 1940, to Aug. 31st 1940, and that I last saw her alive on Aug. 30th 1940.

Immediate cause of death: Uremic Coma — DURATION: 2 days

Due to: Chronic nephritis — 3 yrs.

Due to: Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: C. L. Billingslea
M. D. or other

Address: Westminster, Md. Date signed: 9/2/40

VS A15 (T) MARGIN RESERVED FOR BINDING (I) (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-E)

CERTIFICATE OF DEATH

08474

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Annesley

(If outside city or town limits, write RURAL and give nearest town)

Street No. 518 Murdock Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Minnie Regina Coates

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wilbur C. Coates

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Nov. 4th, ~~1900~~ 1899

8. AGE: Years	Months	Days	If less than one day
40	9	4	hrs. min.

9. Birthplace: Not known (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -----

FATHER — 12. Name: Joseph O'Brien ~~Ind.~~

13. Birthplace: Not known Marianna Gerhauser

MOTHER — 14. Maiden name: Not known Port Deposit, Md.

15. Birthplace: Not known

16. Informant: Records of Springfield State

Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 10, 1940 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Balto. Md.

18. Funeral director: Wm Cook

Address: 1217 St Paul St. Balto.

19. Aug. 8 1940 (Date rec'd by registrar) O. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1940 at 6:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1940, to August 8 1940

and that I last saw h...er alive on August 7 1940

Immediate cause of death	DURATION
Lateral sinus thrombosis	1 week
Due to otitis media	unk.
Due to	
Other conditions Catatonic Stupor	2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Lateral sinus thrombosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lewis Dangy Jr. M.D. M. D. or other

Address: Sykesville Md. Date signed: 8-8-40

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

08475

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 year, 4 days
Stay in this community (yrs., or mos., or days): Same asabove

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 817 Bevans St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: LEWIS Mc KINLEY COBBS

3. (b) Social Security Number: none

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): December 1, 1904

8. AGE: Years	Months	Days	If less than one day
35	8	7	hrs. min.

9. Birthplace: Mississippi (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown

FATHER
12. Name: William Cobbs
13. Birthplace: Alabama

MOTHER
14. Maiden name: Catherine Rogers
15. Birthplace: Mississippi

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 10 1940 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: A. A Co Md

18. Funeral director: Isaiah R Brown Son
Address: 108W Montgomery St

19. August 8 1940 (Date rec'd by registrar) Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8, 1940 19 , at 12:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4 19 39, to August 8 19 40 and that I last saw him alive on August 8 19 40

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1939
Due to: --
Due to: --
Other conditions: --
(Include pregnancy within 3 months of death)
Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Cate of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Superintendent
Address: Henryton, Maryland Date signed: 8/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08476

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Nov. 27, 1939

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? Nov. 27, 1939

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3733 Gough St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: John P. Connolly

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Anna W. Connolly

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): April 20, 1872

8. AGE: Years: 67 | Months: 3 | Days: 22 | If less than one day: ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER — 12. Name: James Connolly

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Bridget King

15. Birthplace: Ireland

16. Informant: Hosp. records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 16-1940 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Road

18. Funeral director: Lilly & Teiler Inc.

Address: 403 S. Wolfe St.

19. Aug. 12, 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12, 1940, at 6 55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1940, to Aug. 12, 1940

and that I last saw h.. alive on Aug. 11, 1940

Immediate cause of death: Bilateral pulmonary tuberculosis with cavitation — DURATION: 10 mos.

Due to:

Due to:

Other conditions: generalized arteriosclerosis; chronic alcoholism

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jerome Hart, M.D.

M. D. or other

Address: Springfield State Hosp. Date signed: Aug. 12/40

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AUG 17 1940
BUREAU V. R.

08477

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(159)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH

County: Carroll

City or town: Sykesville Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Sykesville Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Dorsey (Infant)

3. (b) Social Security Number

4. Sex: M

5. Color or race: Col

6. (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife: none

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 8/6/40

8. AGE: Years ✓ Months ✓ Days ✓ If less than one day: 2 hrs. min.

9. Birthplace: Sykesville Md (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Bernard Johnson

13. Birthplace: Md

MOTHER

14. Maiden name: May Dorsey

15. Birthplace: Md

16. Informant: May Dorsey

Address: Sykesville Md

17. Burial (Burial, cremation, or removal, which?) Date thereof: Aug. 8 1940 (month) (day) (year)

Cemetery or crematory: Bushy Park

Location: Cooksville Md.

18. Funeral director: C. H. Weer

Address: Sykesville Md.

19. Aug 7 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/6 1940, at 1030 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/6 1940, to 8/6 1940, and that I last saw him alive on 8/6 1940.

Immediate cause of death: Premature birth (6 mos)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. S. Barnes MD M. D. or other

Address: Sykesville Md Date signed: 8/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08478

13-8

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 14 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 3 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 635 Hoffman Street

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: ANNA EDNEY

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: James Edney

1004 Argyle Avenue 6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): March 15, 1913

8. AGE:

Years	Months	Days	If less than one day
27	5	14	..... hrs. ..... min.

9. Birthplace: Jacksonboro, South Carolina

(Town, county, and state)

10. Usual occupation: Laundress

11. Industry or business: Unknown

FATHER

12. Name: Castle Fishburn

13. Birthplace: Jacksonboro, South Carolina

MOTHER

14. Maiden name: Virginia Fishburn

15. Birthplace: Jacksonboro, South Carolina

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/3/1940 (month) (day) (year)

Cemetery or crematory: Charlestown

Location: South Carolina

18. Funeral director: A. Adolphus Halstead

Address: 918 Druid Hill Ave.

19. Aug. 29 1940 (Date rec'd by registrar) Albert R. Swanborn Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29th. 1940 at 6:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15, 1940 to August 29 1940

and that I last saw her alive on August 29th, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op. --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.

M. D. or other

Address: Henryton, Maryland Superintendent Date signed: 8/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

08479

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Linden Hills
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Alice Freeman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George W. Freeman
6.(c) If alive, give age: 58 yrs. years

7. Birth date of deceased (mo., day, yr.): 1885

8. AGE: Years	Months	Days	If less than one day
55	?	?	....hrs. ....min.

9. Birthplace: Not known (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: -------

FATHER
12. Name: Not known
13. Birthplace: Not known

MOTHER
14. Maiden name: Not known
15. Birthplace: Not known

18. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address:

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Aug. 22-40 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Frederick, Md.

18. Funeral director: M. R. Etchison & Son
Address: Frederick, Md.

19. (Date rec'd by registrar) Aug. 20 1940 C. Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20, 1940, at 12:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 1940 to August 20 1940 and that I last saw her alive on August 19 1940

Immediate cause of death	DURATION
Uremia	2 weeks
Due to: Chronic nephritis	?
Due to:	
Other conditions: Involutional Psychosis	2-3 months.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D.
M. D. or other
Address: Sykesville, Md. Date signed: Aug. 20, 1940

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SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08480

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or Inst. (yrs., or mos., or days): 3 mos.,17 days

Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 647 Lafayette Avenue
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: WILLIE GAINES

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

8 (b) Name of husband or wife: Eleanora Gaines

6(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): August 17, 1911

8. AGE: Years	Months	Days	If less than one day
28	11	15	____ hrs. ____ min.

9. Birthplace: Charlotte, North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER
12. Name: Rube Gaines
13. Birthplace: unknown

MOTHER
14. Maiden name: Adelaide Tillman
15. Birthplace: unknown

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Cremation Date thereof (month) (day) (year) 8/5/1940

Cemetery or crematory: City Morgue

Location: Baltimore, Md

18. Funeral director: Mrs S. J. Hemsley

Address: 578 W. Biddle St.

19. (Date rec'd by registrar) August 1 19 40 Albert R. Swanhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1, 1940 19 ____, at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 40, to August 1 19 40, and that I last saw him alive on August 1, 1940 19 ____.

Immediate cause of death	Pulmonary Tuberculosis	DURATION Dec 1939
Due to	--	
Due to	--	
Other conditions	--	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 8/1/40

RECEIVED
SEP 5 1940
BUREAU V. S.

08481

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Rural Sykesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Frederick

City or town Brunswick Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 9th Ave. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William F. Good

3. (b) Social Security Number 705-09-1791

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Nuce

6(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1898

8. AGE: Years 42 | Months 7 | Days 20 | If less than one day ___ hrs. ___ min.

9. Birthplace Va. (Town, county, and state)

10. Usual occupation B & O. R.R. Fireman

11. Industry or business

FATHER 12. Name Jeremiah F. Good

13. Birthplace Va.

MOTHER 14. Maiden name Josephine Wetherholt

15. Birthplace Va.

16. Informant Mrs. Mary Good

Address Brunswick, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 30, 1940 (month) (day) (year)

Cemetery or crematory Park Heights Cemetery

Location Brunswick, Md.

18. Funeral director C. H. Feete & Brother

Address Brunswick, Md.

19. Aug. 27 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1940, at 8.50 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —, and that I last saw h — alive on — 19 —.

Immediate cause of death Fractured Skull - Fractured Cervical Vertebrae Multiple fracture all left ribs and 6 rt. ones

Due to Railroad Accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Aug 25 '40

Where did injury occur Sykesville (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (where?) Railroad

Means of injury Railroad Accident Injured at work? Yes.

23. SIGNATURE Jas. T. Marsh. Deputy Medical Examiner M. D. or other

Address New Windsor Md. Date signed 8/28/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08482

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 1 yr., 11 mos., 4 days
Stay in this community (yrs., or mos., or days) Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Nanticoke Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME: NANNIE ALNONA HACKETT

3. (b) Social Security Number: none

4. Sex: Female
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: B. McKinley Hackett
6(c) If alive, give age: unknown yrs
7. Birth date of deceased (mo., day, yr.): December 19, 1902
8. AGE: Years 37 | Months 7 | Days 18 | If less than one day ____ hrs. ____ min.
9. Birthplace: Nanticoke, Maryland (Town, county, and state)
10. Usual occupation: Teacher
11. Industry or business: Unknown
FATHER 12. Name: George Nutter
13. Birthplace: Nanticoke, Maryland
MOTHER 14. Maiden name: Mary Nutter
15. Birthplace: Nanticoke, Maryland
16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 9 1940 (month) (day) (year)
Cemetery or crematory: Nanticoke
Location: Nanticoke md
16. Funeral director: James H. Stewart
Address: Salisbury md
19. August 6 19 40 (Date rec'd by registrar) Albert R. Swanborn Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6, 1940 10:30 A.M. 19 ____, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2 1938, to August 6 1940, and that I last saw her alive on August 6 1940.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Aug, 1937
Due to: --
Due to: --
Other conditions: --
(Include pregnancy within 3 months of death)
Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D.
Superintendent
Address: Henryton, Maryland
M. D. or other
Date signed 8/6/40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08483

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town near Manchester, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 18 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town near Manchester Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME George C. B. Hann

3. (b) Social Security Number —

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widower
6 (b) Name of ~~husband~~ or wife: Alice R Hann (Deceased)
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Oct 27, 1867
8. AGE: Years 72 | Months 9 | Days 26 | If less than one day ____ hrs. ____ min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Samuel Hann
13. Birthplace: unknown
MOTHER 14. Maiden name: Mandika Utz
15. Birthplace: Maryland
16. Informant: Farm Hann
Address: Westminster Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-26-40 (month) (day) (year)
Cemetery or crematory: cemetery
Location: Millers Md
18. Funeral director: Jacob Winter's Sons
Address: Manchester Md
19. Aug. 25th 1940 Mrs. W. P. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 28th 1940 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8th 1940 to Aug 23 1940 and that I last saw him alive on Aug 28th 1940

Immediate cause of death: Acute Dilatation of the Heart — DURATION: 30 Hrs.

Due to: Chronic myocarditus — 1 year

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: L M Resh M. D. or other
Address: Hampstead Md Date signed 8/24/40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08484

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Millington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME LAURA VIRGINIA HICKS

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct, 3, 1919

8. AGE: Years	Months	Days	If less than one day
20	10	3	..... hrs. ..... min.

9. Birthplace Pottstown, Maryland (Town, county, and state)
10. Usual occupation Waitress
11. Industry or business Unknown
FATHER 12. Name Asbury Hicks
13. Birthplace Unknown
MOTHER 14. Maiden name Emma Goldsboro
15. Birthplace Unknown
16. Informant Reuben Hoffman, M. D.
Address Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 7, 1940 (month) (day) (year)
Cemetery or crematory Millington Cem.
Location Millington Md
18. Funeral director W. A. Good.
Address Church Hill Md.
19. August 6, 1940 (Date rec'd by registrar) Albert R. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1940 19..... at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8, 1940 19..... to Augsut 6 19..... 40
and that I last saw h..er alive on August 6, 1940 19.....

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1939
Due to: --
Due to: --
Other conditions: --
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. --
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? --
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D.
Superintendent
M. D., or other
Address Henryton, Maryland Date signed 8/6/40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08485

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mo's. 10 days
Hospital, Institution, or street address where death occurred:
Md. Tuberculosis Sanatorium
Colored Branch
How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME
George Nathan Jackson

3.(b) Social Security Number
214-18-4159

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: ---
6.(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.): December 25, 1917

8. AGE: Years	Months	Days	If less than one day
22	7	10	..... hrs. ..... min.

9. Birthplace: Westport Ga.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug. 6, 1940 (month) (day) (year)
Cemetery or crematory: St. Lukes Cem.
Location: Sykesville Md.
18. Funeral director: C. Harry Lewis
Address: Sykesville Md.
19. 8/4/40 (Date rec'd by registrar) 19.... Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 1940, at 11. P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1940, to Aug. 4, 1940
and that I last saw him alive on August 4, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to ---	April 1940
Due to --	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of
Where did injury occur? ---- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work?

23. SIGNATURE: Reuben Hoffman M. D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 8/4/40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08486

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 326 North Gilmor

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: JESSE JONES

3.(b) Social Security Number: 217-05-7318

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): March 31, 1899

8. AGE:

Years	Months	Days	If less than one day
41	4	29	..... hrs. ..... min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: Unknown

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Maryland

17. Crematori (Burial, cremation, or removal. Which?) Date thereof 9/3/1940 (month) (day) (year)

Cemetery or crematory: Baltimore City Morgue

Location: Baltimore, Md.

18. Funeral director: Mrs Samuel J. Hensley

Address: 578 W. Biddle St.

19. August 29th 40 (Date rec'd by registrar) Albert R. Swankburn Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29th 1940, at 4:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24th 1940, to August 29 1940 and that I last saw him alive on August 29th 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	August 1938
Due to: --	
Due to: --	
Other conditions: --	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op.: --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.

M. D. or other

Address: Superintendent Henryton, Maryland Date signed: 8/29/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08487

159

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Infant (Norris Kenney)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1940

8. AGE:

Years	Months	Days	If less than one day
			1 hrs. min.

9. Birthplace Westminster, Carroll, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Norris Kenney

13. Birthplace Finksburg, Md.

MOTHER 14. Maiden name Margaret Stonesifer

15. Birthplace Finksburg, Md.

16. Informant Clarence Stonesifer

Address Finksburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/11/40 (month) (day) (year)

Cemetery or crematory Finksburg

Location Finksburg, Md.

18. Funeral director J. Francis Reese

Address Westminster, Md.

19. 8/11 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1940, at 2 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from aug 10- 1940, to aug 10 1940 and that I last saw him alive on aug 10- 1940.

	DURATION
Immediate cause of death Prematurity	
5 months development	
Due to	
cause of miscarriage	
Due to unknown.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford M. Taylor M. D., or other

Address Westminster Md. signed 8/11/40

RECEIVED
SEP 4 1940
BUREAU V. S.

08488

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 3 mos., 24 days.
Hospital, institution, or street address where death occurred: Springfield State Hospital.
How long in hospital or institution? 2 yrs., 3 mos., 24 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1533 North Broadway.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: George Klimm.

3. (b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Widowed.

6.(b) Name of ~~husband or~~ wife: Unknown.
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 25, 1854.

8. AGE: Years: 86. Months: 0. Days: 29. If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Laborer.
11. Industry or business:

MOTHER / FATHER
12. Name: Unknown.
13. Birthplace: Unknown.

MOTHER
14. Maiden name: Unknown.
15. Birthplace: Unknown.

16. Informant: Springfield Hospital Record, Sykesville, Md.
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 26, 1940 (month) (day) (year)
Cemetery or crematory: Oakland Cemetery
Location: Baltimore Md.

18. Funeral director: Wm Cook
Address: 1217 St Paul St.

19. Aug 23 1940 (Date rec'd by registrar) C. Harry Dew Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23, 1940, at 3.30 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1938, to Aug. 23, 1940, and that I last saw h. im. alive on Aug. 23 1940.

	DURATION
Immediate cause of death: Chronic Myocardial Degeneration.	2 yrs.
Due to: General Arteriosclerosis prior to 4-30-38.	
Due to:	
Other conditions: Senile Psychosis prior to 4-30-38.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M. D.,
M. D. or other
Address: Sykesville, Md. Date signed: 8-23-40.

RECEIVED
AUG 31 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08489

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Near Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos
Hospital, Institution, or street address, where death occurred: Springfield State Hospital
How long in hospital or institution? 2 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 N. Pine Street
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Joachim Kulbatzki

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lena Kulbatzki
6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): Not Known

8. AGE: Years: 54(?) Months: Days: If less than one day: hrs. min.

9. Birthplace: Not Known - Russia
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Not Known
13. Birthplace: Russia

MOTHER
14. Maiden name: Not Known
15. Birthplace: Russia

16. Informant: Springfield State Hospital Records.
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 16 1940 (month) (day) (year)
Cemetery or crematory: Hebrew Rosedale Cemetery
Location: Baltimore Md.

18. Funeral director: Jack Lewis Inc.
Address: Bald & Caroline Sts

19. Aug. 14 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14 1940 at 1.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Shock	7.
Due to: Fracture of Pelvis	14 hrs.
Due to: Automobile Accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Aug 13/40
Where did injury occur? Crowders Creek Carroll Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Public Road
Means of injury: Automobile Accident Injured at work? No.

23. SIGNATURE: J. J. Shank. Dept. Medical Examiner
M. D. or other
Address: Mt. Windsor Md Date signed: 8/14/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08490

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 65 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Wivie R. Lantz

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife: Clarence M. Lantz

6(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): November 22, 1874

8. AGE: Years	Months	Days	If less than one day
65	8	29	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Thomas Stitely

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Jennette Myerly

15. Birthplace: Maryland

16. Informant: Clarence M. Lantz

Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/23/40 (month) (day) (year)

Cemetery or crematory: Stone Chapel

Location: Warfieldsburg, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 8/22 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20, 1940, at 9p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 3 1940, to Aug. 20 1940, and that I last saw h- alive on Aug. 20 1940.

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to: Coronary Sclerosis	3 years
Due to: Arteriosclerotic Heart Disease and	
Other conditions: Hypertension with Renal Involvement	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Milton A. Katz M.D.
M. D. or other

Address: Westminster Md. Date signed Aug. 21

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

08491

Reg. Dist. No. 78

1. PLACE OF DEATH:

County Carroll

City or town Rural or Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 54 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.D. Westminster, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No.

3. (a) FULL NAME Ephraim Lindsay

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1886

8. AGE:

Years	Months	Days	If less than one day
54	3	15	hrs. min.

9. Birthplace Carroll Co. Maryland.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Joseph Lindsay
13. Birthplace Maryland.

MOTHER
14. Maiden name Clara Baile
15. Birthplace Maryland.

16. Informant Miss Bertie Lindsay
Address R.D. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 1, 1940 (month) (day) (year)

Cemetery or crematory Pipe Creek Meth.

Location near New Windsor, Md.

18. Funeral director C. M. Waltz
Address New Windsor, Md.

19. Sept 1, 1940 (Date rec'd by registrar) E. M. Farver Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30, 1940, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 1940, to August 30 1940, and that I last saw him alive on August 29 1940.

	DURATION
Immediate cause of death — Pneumonia of Pylorus	9 mos.
Due to Duodenal Ulcer	15 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations Laparotomy to prove above.
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Shuster Bon M. D. or other

Address Westminster Md. Date signed 8/30/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

08492

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County. Carroll
City or town. Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 3 mo. 15 da.
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 1 yr. 3 mo. 15 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State. Maryland County.
City or town. Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Unknown
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME Mary Mangrum

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife. Henry Mangrum
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years: Apparent 73 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace. Scotland
(Town, county, and state)

10. Usual occupation. None

11. Industry or business

FATHER
12. Name. Adam Burak
13. Birthplace. Scotland

MOTHER
14. Maiden name. Sarah Boyd
15. Birthplace. Scotland

16. Informant. Hospital Records
Address. Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof. Aug. 30 1940 (month) (day) (year)
Cemetery or crematory. Springfield
Location. Sykesville Md.

18. Funeral director. C. H. Warr
Address. Sykesville Md.

19. Aug 29 1940 (Date rec'd by registrar) C. Harry Warr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH. August 28 1940 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 17 1940, to Aug. 28 1940
and that I last saw h alive on Aug. 24 1940

Immediate cause of death	DURATION
Arteriosclerosis	1936
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations. ..... Date of op. .....
Autopsy results. Arteriosclerosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE. Maud M. Rees M.D.
M. D. or other
Address. Sykesville Md Date signed 8-28-40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08493

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster Rural Near
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 82 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Rural Near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Adam Masenheimer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of ~~husband~~ or wife Emma Grumbeltz
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7 1857

8. AGE:

Years	Months	Days	If less than one day
82	11	24	hrs. min.

9. Birthplace Westminster Carroll Co. Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Adam Masenheimer
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah Ann Harmon
15. Birthplace Pennsylvania

16. Informant Mrs Guy Smith
Address Westminster Md R. D.

17. Burial Date thereof Sept. 3, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Silversrun Cemetery
Location Silversrun Carroll Co. Maryland

18. Funeral director H Bankard & Son
Address Westminster Maryland

19. 9/2 1940 H Bankard & Son
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31st 1940, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1940, to August 31st 1940, and that I last saw him alive on August 31st 1940.

	OURATION
Immediate cause of death Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J Stewart M. D. or other
Address Westminster Md Date signed Sept 1 1940

RECEIVED
SEP 4 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

08494

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yrs. and 27 da.

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 28 yrs. and 27 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. Unknown

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Catherine Mason

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Unknown

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Patient 74			..... hrs. ..... min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Hospital Records

Address Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 14 1940 (month) (day) (year)

Cemetery or crematory Springfield

Location Sykesville Md.

18. Funeral director C. H. Kees

Address Sykesville Md.

19. Aug. 12 1940 (Date rec'd by registrar) C. Harry Kees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1940, at 1.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1940, to Aug. 11 1940

and that I last saw h.. alive on Aug. 10 1940

Immediate cause of death	DURATION
Bronchopneumonia	2 da
Due to	
Automobile accident	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as foregoing

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mary M. Rees M.D. M. D. or other

Address Sykesville Md. Date signed 8-14-40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (83a)

08495

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:
County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Carroll
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1114 Brentwood Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Joseph Leo McAdams
3. (b) Social Security Number 213-03-3501

4. Sex M.
5. Color or race W.
6. (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Elizabeth McAdams
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) August 11, 1910
8. AGE: Years 30 ~~27~~ Months 0 Days 3 If less than one day hrs. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual occupation Truck Driver
11. Industry or business Trucking (Freight)
FATHER 12. Name Wm McAdams
13. Birthplace Baltimore Md
MOTHER 14. Maiden name Cammill
15. Birthplace Baltimore Md
16. Informant D. G. Smith - Employer
Address Baltimore Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 17, 1940 (month) (day) (year)
Cemetery or crematory ~~Holy Redeemer Cemetery~~ New Cathedral
Location ~~4500 Belair Road~~ Baltimore
18. Funeral director Elmer W. Conklin & Son
Address 924 E. Eager St.
19. Aug. 14 1940 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1940, at 9 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —,
and that I last saw h — alive on — 19 —.
Immediate cause of death Cerebral Hemorrhage
Due to —
Due to —
Other conditions —
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Jas. T. Marsh, Deputy Medical Examiner M. D. or other
Address New Windsor Md Date signed Aug. 14. 40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 22 1940
BUREAU V. S.

08496

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 6 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1303 W. 42nd St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Catherine Minitor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Minitor

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 1, 1871

8. AGE: Years	Months	Days	If less than one day
69		30	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Schroen
13. Birthplace: ~~Bet~~ Germany

MOTHER
14. Maiden name: Eva Dickson
15. Birthplace: Germany

16. Informant: Mrs. Wm. J. Fisher

Address: 1303 W. 42nd St., Baltimore, Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 9/3/40 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Balto. Md.

18. Funeral director: Chas. F. Evans & Son Inc

Address: 118 W. Mt. Royal Ave

19. Sept. 1 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 31, 1940, at 9:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 6, 1940, to Aug. 31, 1940 and that I last saw her alive on Aug. 31, 1940

Immediate cause of death	DURATION
Hypertensive cardiovascular disease	5 yrs.
Generalized arteriosclerosis	5 yrs.
~~Due to~~ Cerebral hemorrhages	4 yrs., 3 yrs., and 45 days
~~Due to~~ Hypostatic pneumonia, bronchial, in type. Duration: one day.	1 day.
Other conditions: C.W.G.R.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M. D.
M. D. or other

Address: Springfield State Hospital Date signed: Aug. 31, 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4635)

08497

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Manchester
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 25 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Manchester Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Edgar S Nagle

3. (b) Social Security Number —

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Arie Nagle
Deceased 6(c) If alive, give age years.

7. Birth date of deceased (mo., day, yr.) March 11 1878

8. AGE: Years	Months	Days	If less than one day
62	5	8	hrs. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Owner
11. Industry or business Canning industry
FATHER 12. Name Conrad S Nagle
13. Birthplace Germany
MOTHER 14. Maiden name Sarah Bilhart
15. Birthplace Maryland
16. Informant Wm. I Nagle
Address Greenmount Md
17. Burial Date thereof Aug 21/40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenmount
Location Greenmount Md
18. Funeral director Edw C Tipton
Address Hampstead Md
19. Aug. 20th 1940 Mrs. W. P. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1940, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1 1940, to Aug 19 1940, and that I last saw h[illegible] alive on Aug 19 1940.

Immediate cause of death	DURATION
Cancer of Stomach & Liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations Cancer
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William R S Denner
M. D. or other
Address Manchester Md Date signed 8/20/40

RECEIVED
SEP 5 1940
BUREAU V. S.

08498

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 35 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. Not known

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Carlton O.Pfoutz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) May 4,1865

8. AGE:

Years	Months	Days	If less than one day
75	3		... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Not known

FATHER

12. Name: John Pfoutz

13. Birthplace: Maryland

MOTHER

14. Maiden name: Anna E. Repp

15. Birthplace: Maryland

16. Informant: Hospital Record

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 6, 1940 (month) (day) (year)

Cemetery or crematory: Pipe Creek

Location: Union town

18. Funeral director: Raymond W. Wright

Address: Union Bridge Md

19. Aug. 4 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4,1940 19... at 4:30AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept.1,1938 19... to Aug.4,1940 19...

and that I last saw him alive on August 3,1940 19...

Immediate cause of death: Chronic Myocarditis — DURATION: prior to 1940

Due to: Arteriosclerosis

Due to:

Other conditions: Generalized arteriosclerosis; Dementia Praecox — 35 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Samuel Barkoff M.D. M. D. or other

Address: Sykesville, Md. Date signed 8/4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

08499

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

(942)

County Carroll Co. Registration Dist. No. 76

Village or City near Westminster Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 4 yrs. 6 mos. — ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

Mary E. Prunty If U. S. Veteran, specify WAR

(a) Residence: No. Balt. Westminster St. Md Ward. Baltimore, Md.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) Dec. 21-1872

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Semstres.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Balto. Md. (State or country)

FATHER

13. NAME John. E. Prunty

14. BIRTHPLACE (city or town) — (State or country)

MOTHER

15. MAIDEN NAME Dorthy Martin

16. BIRTHPLACE (city or town) — (State or country)

17. INFORMANT Ella L. Renehart. (Address) 724 E. 24 St.

18. BURIAL, CREMATION, OR REMOVAL Place Myer-Balto. Date Aug 5, 1940

19. UNDERTAKER John. A. Myers (Address) 3000 E. Balto. St.

20. FILED 8/1, 1940 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH August 1st, 1940 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 31, 1940, to July 31, 1940

I last saw her alive on July 31, 1940; death is said to have occurred on the date stated above, at 4:30 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: Angina Pectoris — Date of onset

Other Contributory Causes of Importance: Chronic Endocarditis

Name of operation — Date of

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or In PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or Injury in any way related to occupation of deceased?

If so, specify

(Signed) John L. Smart M. D.

(Address) Westminster

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

RECEIVED
SEP 4 1940
HENRAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

08500

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(940)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 31 Westmoreland
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 36 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 31 Westmoreland
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Laura Jane Royer

3. (b) Social Security Number none

4. Sex F.
5. Color or race W.
6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 20. 1861
8. AGE: Years 78 Months 7 Days 20 If less than one day hrs. min.
9. Birthplace Bachmans Valley Carroll Co. Md.
(Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name John Royer
13. Birthplace Md.
MOTHER 14. Maiden name Elizabeth Geiman
15. Birthplace Md.
16. Informant Mrs Edwin C. Snader
Address 31 Westmoreland Street, Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 20. 1940 (month) (day) (year)
Cemetery or crematory Meadowbranch Cem.
Location M. Westminster, Maryland
18. Funeral director H Bankard & Son
Address Westminster, Maryland.
19. 8/19 1940 (Date rec'd by registrar) L K Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17th, 1940, at 5:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1937, to Aug. 17 1940, and that I last saw her alive on Aug. 14th 1940.
Immediate cause of death Cerebral Thrombosis — DURATION 4 days
Due to Arterio Sclerosis — 3 yrs.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L K Woodward M. D. or other
Address Westminster Date signed 8/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1940
U. S. DEPT. OF AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08501

Reg. Dist. No. 79

1. PLACE OF DEATH:

County: Carroll

City or town: Detour

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Detour

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: William David Schildt

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maggie Fow Schildt

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Dec. 14th. ~~19~~ 1869

8. AGE: Years	Months	Days	If less than one day
70	8	7	...hrs. ...min.

9. Birthplace: Penna. (Town, county, and state)

10. Usual occupation: Retired. Mail Carrier

11. Industry or business

FATHER — 12. Name: David Schildt

FATHER — 13. Birthplace: Penna

MOTHER — 14. Maiden name: Elizabeth Jones.

MOTHER — 15. Birthplace: York Penna

16. Informant: Mrs Wm. D. Schildt.

Address: Detour MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 23rd. 40 (month) (day) (year)

Cemetery or crematory: Cemetery Haughs. Frdk. Co. Md

Location

18. Funeral director: M. L. Creager & Son.

Address: Thurmont. MD

19. Aug 21 1940 (Date rec'd by registrar) Mrs Nancy M. Kuser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 21st. 1940 at 12:45 at A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1940, to Aug 20 1940

and that I last saw h... alive on Aug 20 1940

Immediate cause of death	DURATION
Pneumonia - Cerebral	2 weeks
Due to: Cerebral Arteriosclerosis	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James K Gray DR. JAMES K GRAY M. D. or other

Address: Thurmont - Md. Date signed: Aug 21-1940

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

CEIVED
SEP 4 1900
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08502

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs., 7 mos., 23 days.
Hospital, institution, or street address where death occurred: Springfield State Hospital.
How long in hospital or institution? 26 yrs., 7 mos., 23 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3217 Vickers Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Lionel Scrimger.

3.(b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Exact date unknown.

8. AGE: Years	Months	Days	If less than one day
74.	Unk.	Unk.	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Lawyer and Salesman.
11. Industry or business:

FATHER
12. Name: Peter W. Scrimger.
13. Birthplace: Virginia.

MOTHER
14. Maiden name: Mary Lee.
15. Birthplace: Virginia.

16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Aug. 8, 1940 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Baltimore, Md.

18. Funeral director: Wm. M. Marsch.
Address: Light & Montgomery Sts.

19. Aug. 6 1940 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6, 1940, at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1936, to Aug. 6, 1940.
and that I last saw him alive on Aug. 6, 1940.

Immediate cause of death	DURATION
Cerebral Arteriosclerosis	6 years.
Due to:	
Due to:	
Other conditions: Myocardial Degeneration	6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D., M. D. or other
Address: Sykesville, Md. Date signed 8-6-40.

RECEIVED
SEP 5 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08503

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 4 Mo's. 26 days
Hospital, Institution, or street address where death occurred:
Md. Tuberculosis Sanatorium
Colored Branch, Same as above
How long in Hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1422 Rutter Street
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Woodrow Wilson Simmons

3.(b) Social Security Number: 213-14-9159. None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): Sept., 8, 1919

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
21	10	27		

9. Birthplace: Unknown, Virginia (Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business: Unknown
FATHER 12. Name: Vernon Simmons
13. Birthplace: Virginia
MOTHER 14. Maiden name: Lillian Walker
15. Birthplace: Virginia
16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.
17. Removal (Burial, cremation, or removal—which?) Date thereof (month) (day) (year)
Cemetery or crematory: city marque falls ave
Location:
18. Funeral director: mrs S. T. Hensley
Address: 578 W. Biddle St
19. 8/4/ 1940 (Date rec'd by registrar) Albert R. Swanbrow Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4, 1940, at 3.10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9, 1939, to Aug., 4, 1940 and that I last saw him alive on August 4, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan., 1939
Due to: ---	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 8/4/40

RECEIVED
AUG 23 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(8) 08594

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:

County Carroll

City or town Hampstead, Rural near
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Mayland County Carroll

City or town Hampstead, Rural near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Singer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4 1940

8. AGE: Years — Months — Days — If less than one day 1 hrs. min.

9. Birthplace Mayland
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name C Edward Singer

13. Birthplace Mayland

MOTHER 14. Maiden name Maizie L. Weaver

15. Birthplace Mayland

16. Informant C Edward Singer

Address Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof aug 5/40 (month) (day) (year)

Cemetery or crematory Wesley

Location Carroll County, Md

18. Funeral director Edward C Tipton

Address Hampstead Md.

19. Aug. 4 19 40 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3 1940, at 8a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-4 1940, to 8-3 1940, and that I last saw h alive on Born dead 19

Immediate cause of death Collapse of umbilical Cord — DURATION 1 hr.

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Mamie C. Partridge M. D. or other

Address Hampstead, Md Date signed 8-3-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-D

CERTIFICATE OF DEATH

08505

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 hours

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 27 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3505 Forest Park Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Fannie Smulowitz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: Samuel Smulowitz

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE:

Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Unknown

13. Birthplace: Poland

MOTHER

14. Maiden name: Unknown

15. Birthplace: Poland

16. Informant: Daughter - Mrs. S. Meyerberg

Address: 3505 Forest Park Ave., Balt. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 15, 1940 (month) (day) (year)

Cemetery or crematory: Hebrew Friedel Cem.

Location: Balto., Md.

18. Funeral director: Jos. Lewis Sons

Address: Balto. & Caroline Sts.

19. Aug. 13 1940 (Date received by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13 1940 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 13 1940, to August 13 1940

and that I last saw her alive on August 13 1940

	DURATION
Immediate cause of death: Arteriosclerosis	2 years
Due to: Chronic Myocarditis and	Months
Due to: Myocardial Degeneration	5 years
Due to:	
Other conditions: Adherent Pericarditis	Unknown
Cerebral Edema	Aug. 13- 1940

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D. (M. D. or other)

Address: Sykesville, Md. Date signed: Aug. 13-1940

RECEIVED
AUG 18 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

08506

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll.

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 1 mo., 20 days.

Hospital, institution, or street address where death occurred: Springfield State Hospital.

How long in hospital or institution? 1 yr., 1 mo., 20 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland, County: Garrett.

City or town: Oakland (?)
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George W. Sowers.

3. (b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Married.

6.(b) Name of ~~husband or~~ wife: Missoura B. Sowers.

6.(c) If alive, give age 62. years

7. Birth date of deceased (mo., day, yr.): July 31, 1866.

8. AGE:

Years	Months	Days	If less than one day
74.	0.	8.	hrs. min.

9. Birthplace: Oakland, Md.
(Town, county, and state)

10. Usual occupation: Stable Boss.

11. Industry or business: Coal Company.

FATHER
12. Name: John Alexander Sowers,
13. Birthplace: Oakland, Md.

MOTHER
14. Maiden name: Mary M. Hilberg.
15. Birthplace: Koppel, Germany.

16. Informant: Springfield Hospital Record,
Address: Sykesville, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 9, 1940 (month) (day) (year)

Cemetery or crematory: Oakland

Location: Oakland, Md.

18. Funeral director: J. D. Duncan

Address: Thomas, Wes Va

19. Aug 9 1940 (Date rec'd by registrar) C. Harry Weer, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9, 1940. at 5:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19, 1939, to Aug. 9, 1940. and that I last saw him alive on August 9, 1940.

Immediate cause of death: Cerebral Arteriosclerosis prior to 6-19-39.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Harry F. Baer, M. D., M. D. or other

Address: Sykesville, Md. Date signed 8-9-40.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 5 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93 d)

CERTIFICATE OF DEATH

08507

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4617 Park Heights Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Philip Spanpinato

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Angelina Pistorio
6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): 1854

8. AGE: Years	Months	Days	If less than one day
86	?	?	....hrs. ....min.

9. Birthplace: Italy (Town, county, and state)
10. Usual occupation: Unemployed since 1914
11. Industry or business:
12. FATHER — Name: Leonardo Spanpinato
13. FATHER — Birthplace: Italy
14. MOTHER — Maiden name: Maria Morgano
15. MOTHER — Birthplace: Italy
16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 28, 1940 (month) (day) (year)
Cemetery or crematory: Holy Redeemer Cemetery
Location: Baltimore Md.
18. Funeral director: Wm Cook
Address: 1217 St Paul St. Balto.
19. Aug. 26 1940 (Date received by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25, 1940 at 9:15p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20 1940 to August 25 1940 and that I last saw h...im alive on August 25 1940

Immediate cause of death	DURATION
Chronic Myocarditis	Over
Due to: Generalized Arteriosclerosis	six yrs
Due to:	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Alan Jacobus M. D. or other
Address: Sykesville, Md. Date signed: 8/26/40

RECEIVED
AUG 28 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

08508

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Upperco, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 24 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural near Upperco Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Girl Tipton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1940

8. AGE: Years | Months | Days | If less than one day ___hrs. ___min.

9. Birthplace Upperco, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Ray Cecil Tipton

FATHER 13. Birthplace Bakersville, N. C.

MOTHER 14. Maiden name Edith Lyle Laws

MOTHER 15. Birthplace Burnsville, N. C.

16. Informant

Address

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22 1940 ?, at ___ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-22-40 1940, to 8-22 1940,

and that I last saw h alive on Burn dead 19

Immediate cause of death Still Birth — DURATION

Due to Anencephalic Monstrosity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice C. Partenfield M. D. or other

Address Hanover Md Date signed 9-20-40

S.
Sig.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08509

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 19 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 1 month, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give resideoce of mother)

State: Maryland County: Worcester

City or town: Snow Hill

(If outside city or town limits, write RURAL and give nenrest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: FRANK VICTOR

3. (b) Social Security Number: 220-01-7377

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 15, 1917

8. AGE: Years	Months	Days	If less than one day
23	0	1	hrs. min.

9. Birthplace: SNow Hill, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER — 12. Name: Will Purnell

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: Grace Collins

MOTHER — 15. Birthplace: Snow Hill, Maryland

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Maryland

17. Burial (Burial, eremation, or removal? Which?) Date thereof: Aug. 19 1940 (month) (day) (year)

Cemetery or crematory: Snow Hill Cem.

Location: Snow Hill Md.

18. Funeral director: Clay. E. Dennis

Address: Snow Hill Md.

19. August 16 1940 (Date rec'd by registrar) Albert R. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16, 1940 19 at 3:00 AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 19 40 to August 16 19 40

and that I last saw h im alive on August 16 19 40

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1940

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op. --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.

M. D. or other

Superintendent

Address: Henryton, Maryland Date signed: 8/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08510

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos., 28 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 4 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 131 S. Caroline Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES WALKER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Julia Walker

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): April 23, 1902

8. AGE: Years	Months	Days	If less than one day
38	3	9	...hrs. ...min.

9. Birthplace: Old Grove, Maryland, Kent Co. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER — 12. Name: William Walker

FATHER — 13. Birthplace: Old Grove, Kent Co., Md.

MOTHER — 14. Maiden name: Vina Thatcher

MOTHER — 15. Birthplace: Unknown

16. Informant: Wm. A. Ventimiglia, M. D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 2nd 1940 (month) (day) (year)

Cemetery or crematory: Mt Calvery

Location: Brookland, Md

18. Funeral director: Elroy O Wilson

Address: 1600 - Brantley Ave

19. August 1 1940 (Date rec'd by registrar) Albert R. Franklin Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1, 1940 at 8:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1940, to August 1 1940

and that I last saw h...im...alive on August 1, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op. -- p

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Wm. A. Ventimiglia M.D. M. D. or other

Address: Henryton, Maryland Date signed 8/1/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 2 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

08511

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll.

City or town: Sykesville, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months.

Hospital, institution, or street address where death occurred: Springfield State Hospital,

How long in hospital or institution? 9 months.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland, County:

City or town: Baltimore, (If outside city or town limits, write RURAL and give nearest town)

Street No. ~~[illegible]~~ 822 Burgundy St., (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME William West.

3. (b) Social Security Number ✓

4. Sex: Male.

5. Color or race: White.

6.(a) Single, married, widowed, or divorced: Married.

6.(b) Name of ~~husband or~~ wife: Hethe West.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 22, 1874.

8. AGE: Years 66. Months 2. Days 22. If less than one day ..... hrs. ..... min.

9. Birthplace: Harnett Co., N.C. (Town, county, and state)

10. Usual occupation: Carpenter.

11. Industry or business:

FATHER
12. Name: John R. West,
13. Birthplace: Samson Co., N.C.

MOTHER
14. Maiden name: Hanna Page.
15. Birthplace: Samson Co., N.C.

16. Informant: Springfield Hospital Record,
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 17, 1940 (month) (day) (year)

Cemetery or crematory: Lilington Am.

Location: Lilington N.C.

18. Funeral director: Frank Coach

Address: 901 N. Chester St Balto

19. Aug. 14 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13, 1940, at 11:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18, 1940, to August 13, 1940, and that I last saw him alive on August 13, 1940.

Immediate cause of death: Cerebral Arteriosclerosis prior to 11-14-39.

Due to: Terminal lobar pneumonia, due to venous hypostasis. C.W.S.R.

Due to:

Other conditions: Hypostatic Pneumonia; lobar, in type; 3 days. (Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D. M. D. or other

Address: Sykesville, Md. Date signed: 8-13-40.

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08512

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs., 4 mos., 7 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 10 yrs., 4 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3624 Manchester Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Luther W. Willen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Leila ?
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 9, 1881

8. AGE: Years	Months	Days	If less than one day
59	3	25	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Seaman
11. Industry or business: ----

FATHER
12. Name: Dandridge Willen
13. Birthplace: Virginia

MOTHER
14. Maiden name: Susan Reynolds
15. Birthplace: Virginia

16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 8, 1940 (month) (day) (year)
Cemetery or crematory: Village Cemetery
Location: Village, Va.
18. Funeral director: A. C. McKenney
Address: Village, Va.
19. Aug. 6 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 1940 at 1:15 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1930 to August 4 1940 and that I last saw him alive on August 3 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 mos.
Due to	
Due to	
Other conditions: Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lewis Young jr. M. D. (M. D. or other)
Address: Sykesville, Md. Date signed: 8-9-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 5 1940
BUREAU V. S.

08513

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Benedum Street

Stay in hospital or insl. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Benedum Street.
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Arthur Yingling

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Annie Hann Yingling

6(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): July 11 - 1862

8. AGE: Years 78 | Months 1 | Days 2 | If less than one day ___ hrs. ___ min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Upholsterer (Retired)

11. Industry or business: Western Maryland Railway

FATHER
12. Name: Edmund Yingling.
13. Birthplace: Carroll Co, Maryland.

MOTHER
14. Maiden name: Agnes Ernst.
15. Birthplace: Pennsylvania

16. Informant: Mrs Wilbur Fowble
Address: Union Bridge, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 16 - 40 (month) (day) (year)

Cemetery or crematory: Mt View.

Location: Union Bridge, Md.

18. Funeral director: D. D. Hauter & Sons
Address: Union Bridge, Md.

19. Aug 14 1940 (Date rec'd by registrar) P. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 13 1940, at 6 45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 1940, to Aug 13 1940, and that I last saw him alive on Aug 12 1940.

Immediate cause of death: Arterio Sclerosis

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: T. H. Legg M. D. or other
Address: Union Bridge Date signed: 8-14-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 5 1940
BUREAU V. S.